

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-2655-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Pacific Employers Insurance Co. Box 15	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: C290C1746437

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/12/03	06/17/03	97139-TN & E1399	\$90.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 09/29/03 states in part, "...Our original audit for date of service 6-17-03 was denied because of the code we used for Electrodes. We submitted in with corrected code as a request for reconsideration. For date of service 3/12/03 a partial payment was made for our charge. We submitted in our usual and customary charge as a request for reconsideration. To date we have not had a response from the carrier regarding our reconsiderations..."

PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a position summary.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97139-TN for date of service 03/12/03 denied as "M". Per Rule 133.1(a)(8) the requestor has not shown the amount billed to be their usual and customary amount; therefore, reimbursement is not recommended.

Originally the requestor billed HCPCS Code A4556 for the TENS unit supplies; upon reconsideration the requestor billed HCPCS Code E-1399 for date of service 06/17/03. The initial denial for the TENS unit supplies is "G". Per the 1996 MFG the global fee concept applies only to surgical procedures. Therefore reimbursement in the amount of \$85.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
3/12/2003	97139-TN	\$5.00	\$0.00				
6/17/2003	E1399	\$85.00	\$85.00				
				Total Left Column:			\$90.00
				Total Amount Due:			\$85.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$85.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Marguerite Foster	12/17/04
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Marguerite Foster	12/17/04
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Authorized Signature

Typed Name

Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____